STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of the Department of Insurance and Financial Services

In the matter of:

My Premier Nursing Care
Petitioner **File No. 21-1747**

v

Progressive Michigan Insurance Company
Respondent

Issued and entered
this 19th day of January 2022
by Sarah Wohlford
Special Deputy Director

ORDER

I. PROCEDURAL BACKGROUND

On November 18, 2021, My Premier Nursing Care (Petitioner) filed with the Department of Insurance and Financial Services (Department) a request for an appeal pursuant to Section 3157a of the Insurance Code of 1956 (Code), 1956 PA 218, MCL 500.3157a. The request for an appeal concerns the determination of Progressive Michigan Insurance Company (Respondent) that the cost of treatment, products, services, or accommodations that the Petitioner rendered was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner's appeal is based on the denial of a bill pursuant to R 500.64(3), which allows a provider to appeal to the Department from the denial of a provider's bill. The Respondent issued the Petitioner bill denials on September 15 and 23, 2021; October 12, 13, 25, and 27, 2021; and November 1, 2021. The Petitioner seeks reimbursement in the full amount it billed for the dates of service at issue.

The Department accepted the request for an appeal on December 2, 2021. Pursuant to R 500.65, the Department notified the Respondent and the injured person of the Petitioner's request for an appeal on December 2, 2021 and provided the Respondent with a copy of the Petitioner's submitted documents. The Respondent filed a reply to the Petitioner's appeal on December 14, 2021.

II. FACTUAL BACKGROUND

This appeal concerns the appropriate reimbursement amount for home health services rendered on 58 dates of service[1] under Healthcare Common Procedure Coding System (HCPCS) Level II code G0156 with a TG modifier. The procedure code is described as home health aide, in a home or hospice setting, each 15 minutes and the TG modifier is described as complex/high tech level of care.

With its appeal request, the Petitioner submitted documentation that included 7 *Explanation of Benefits* (EOB) letters issued by the Respondent, a prescription signed by a physician prescribing home care for 12 hours a day 7 days a week, its 2019 charge description master (CDM), and a narrative outlining its reason for appeal.

The Petitioner's request for an appeal stated:

> According to the DIFS No-Fault Fee Schedule, R 500.203 Medicare Calculation, Rule 3, when calculating the amount payable to a provider for a service under Medicare part A or B, as referenced in section 3157 of the act, MCL 500.3157, the amounts payable to participating providers under the applicable fee schedule shall be utilized. An amount payable pursuant to the fee schedule may not exceed the average amount charged by the provider for service on January 1, 2019 … Additionally, we have met the criteria for NOT receiving a reduction. We have used a Medicare billing code with a fee schedule attached, we have sent our 2019 chargemaster. 2019 rates can easily be verified by the [Respondent] since this is an established rate between us for several years.

In its EOBs, the Respondent stated that it provided a reimbursement rate based on the applicable percentage of the Petitioner's CDM and further adjusted by the annual adjusted consumer percentage index (CPI). In its reply, the Respondent explained:

> [W]e correctly issued payment to the [Petitioner] in this matter for each and every submission, as can be seen in the Notices of Determination/Explanation of Benefits attached to this reply at 55% and an additional 4.11%. It is extremely important to point out that this [Petitioner] prior to the July 1, 2021 amendment of MCL 500.3157 was billing Progressive for the same services at issue in this appeal using CPT Code S9122 (see attached EOB's from 6/27/21-7/1/21). Since the amendment, they are now attempting to bill for the same services using CPT Code G0156, so as to 1) bill a higher rate; 2) bill in 15 minute increments; 3) attempt to argue they should get 200% of that figure…the [Respondent] does not owe any further payments, as 24 hour in home attendant care is not payable by Medicare and falls directly within MCL 500.3157(7)(i).

[1] The dates of service at issue are August 8 through October 4, 2021.

On December 2, 2021, the Department requested that the Petitioner submit its CDM. *See* MCL 500.3157(7). The Petitioner submitted its CDM to the Department on December 3, 2021.[2]

III. ANALYSIS

Director's Review

Under MCL 500.3157a(5), a provider may appeal an insurer's determination that the provider overutilized or otherwise rendered inappropriate treatment, products, services, or accommodations, or that the cost of the treatment, products, services, or accommodations was inappropriate under Chapter 31 of the Code. This appeal involves a dispute regarding cost.

For dates of service after July 1, 2021, MCL 500.3157 governs the appropriate cost of treatment and training. Under that section, a provider may charge a reasonable amount, which must not exceed the amount the provider customarily charges for like treatment or training in cases that do not involve insurance. Further, a provider is not eligible for payment or reimbursement for more than specified amounts. For treatment or training that has an amount payable to the person under Medicare, the specified amount is based on the amount payable to the person under Medicare. If Medicare does not provide an amount payable for a treatment or rehabilitative occupational training under MCL 500.3157(2) through (6), the provider is not eligible for payment or reimbursement of more than a specified percentage of the provider's charge description master in effect on January 1, 2019 or, if the provider did not have a charge description master on that date, an applicable percentage of the average amount the provider charged for the treatment on January 1, 2019. Reimbursement amounts under MCL 500.3157(2), (3), (5), or (6) may not exceed the average amount charged by the provider for the treatment or training on January 1, 2019. See MCL 500.3157(8); MAC R 500.203.

MCL 500.3157(15)(f) defines "Medicare" as "fee for service payments under part A, B, or D of the federal Medicare program established under subchapter XVIII of the social security act, 42 USC 1395 to 1395lll, without regard to the limitations unrelated to the rates in the fee schedule such as limitation or supplemental payments related to utilization, readmissions, recaptures, bad debt adjustments, or sequestration." Under MAC R 500.203, reimbursements payable to providers are calculated according to "amounts payable to participating providers under the applicable fee schedule." "Fee schedule" is defined by MAC R 500.201(h) as "the Medicare fee schedule or prospective payment system in effect on March 1 of the service year in which the service is rendered and for the area in which the service was rendered." Accordingly, reimbursement to providers under MCL 500.3157 is calculated either on a fee schedule (i.e., fee-for-service) basis or on a prospective payment system basis.

[2] The Department also requested that the Petitioner submit documentation in the form of bills and reimbursements from insurers to support the rate charged on January 1, 2019. The supporting documentation showed an average charge of $[redacted] per hour for HCPCS Level II code G0156.

HCPCS Level II Code G0156 has an amount payable under Medicare when it is billed on a prospective payment system basis. No payment amount is available for HCPCS Level II Code G0156 under on a fee-schedule basis because that code is not priced separately. Although the Petitioner stated that it was billing on the basis of the HHPPS, the Petitioner did not provide any supporting documentation to substantiate this assertion. Where there is no amount payable under Medicare, reimbursement is calculated based on a provider's charge description master or average amount charged on January 1, 2019. See MCL 500.3157(7).

To calculate the appropriate reimbursement amount, the Department relied on the Petitioner's average amount charged[3] as of January 1, 2019 for HCPCS Level II code G0156 with a TG modifier. Pursuant to MCL 500.3157(7), the amount payable to the Petitioner for the procedure code at issue for the dates of service at issue is listed in the table below:

HCPCS code	January 1, 2019 average amount charged	55% of the January 1, 2019 average amount charged	4.11% CPI adjustment	Amount payable for the dates of service at issue
G0156-TG	$[redacted]	$[redacted]	$[redacted]	$[redacted]/unit

Accordingly, the Department concludes that the Petitioner is due additional reimbursement for the dates of service at issue.

IV. ORDER

The Director reverses the Respondent's determination dated September 15 and 23, 2021, October 12, 13, 25, and 27, 2021, and November 1, 2021 that the cost of the treatment on the dates of service at issue in this appeal was inappropriate under Chapter 31 of the Code, MCL 500.3101 to MCL 500.3179.

The Petitioner is entitled to reimbursement in the amount payable under MCL 500.3157 for the treatment on the dates of service discussed herein, and to interest on any overdue payments as set forth in Section 3142 of the Code, MCL 500.3142. R 500.65(6). The Respondent shall, within 21 days of this order, submit proof that it has complied with this order.

This order applies only to the treatment and dates of service discussed herein and may not be relied upon by either party to determine the injured person's eligibility for future treatment or as a basis for action on other treatment or dates of service not addressed in this order.

[3] The CDM submitted by the Petitioner lists procedure code G0156 as an hourly charge, as opposed to 15-minute increments. For calculation purposes, the Department divided the hourly charge by four to establish the 15-minute unit charge.

This is a final decision of an administrative agency. A person aggrieved by this order may seek judicial review in a manner provided under Chapter 6 of the Administrative Procedures Act of 1969, 1969 PA 306, MCL 24.301 to 24.306. MCL 500.244(1); R 500.65(7). A copy of a petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of Research, Rules, and Appeals, Post Office Box 30220, Lansing, MI 48909-7720.

Anita G. Fox
Director
For the Director:

X Sarah Wohlford

Sarah Wohlford
Special Deputy Director
Signed by: Sarah Wohlford